CALIGRA MANAGEMENT, LLC
1201 ELKFORD LANE
JUSTIN, TX 76247
817-726-3015 (phone)
888-501-0299 (fax)

Notice of Independent Review Decision

April 29, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Six sessions of individual psychotherapy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Psychiatrist

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who on xx/xx/xx, was rear-ended by a truck. He started with having left wrist pain and discomfort in his neck. The next day, the neck pain worsened.

2013: In a functional capacity evaluation (FCE) performed on September 25, 2013, it was noted that the patient was not capable of physically performing all of his pre-injury work demands. His maximum work physical demand levels (PDL) for lifting were in the medium PDL (50-75 pounds) frequently and he presented lifting abilities in the sedentary to light PDL (20-30 pounds). Previously, he was in the less than sedentary to sedentary PDL (0-15 pounds). The patient complained of mild-to-moderate pain sensation of 5-7/10 during testing and exhibited outward

pain behavior pattern and acute distress. recommended transition to a two weeks (10 sessions) work conditioning program (WCP) to address the remaining overlying physical and functional deficits and allowed him to increase his overall function.

Per DWC-69 dated November 4, 2013, opined that the patient was not at MMI. The patient was expected to reach MMI on or about January 4, 2014.

2014: On January 22, 2014, saw the patient for continued 6-8/10 low back pain with radiation. The patient noted increased low back pain shooting into the left leg stopping at the knee. He stated that he was unable to sleep at night without ibuprofen. He noted that ibuprofen was now losing its effect. On examination, the patient presented with a tilt in walking, slightly bent forward. There was slight atrophy noted in the lower extremities. Sensation was decreased (4/5) in the left lower extremity at the L4. Deep tendon reflexes (DTRs) were decreased (+1) at the L4 on the left. Muscle spasm was noted in the lumbar paraspinals. diagnosed lumbar radiculitis, low back pain, lumbar sprain/strain and muscle spasm. The patient was instructed to schedule appointment to discuss injection treatment.

On February 10, 2014, saw the patient for an initial diagnostic screening. The patient complained of mood disturbances, anxiety, sleep disturbances, vocational concerns, psychological stressors and physical limitations. reviewed the medical records that were provided and noted he was treated for injury sustained on xx/xx/xx. From July 11, 2013, through January 22, 2014, the patient was under the care for therapy for pain. The patient was seen on October 24, 2013, for pain in bilateral neck and posterior thoracic area. scheduled him for cervical epidural steroid injection (ESI) at C5-C6 and continued him on physical therapy (PT). Per a magnetic resonance imaging (MRI) dated September 11, 2013, he was found to have multiple disc pathology in the cervical spine. Electromyography/nerve conduction velocity (EMG/NCV) study done on November 20, 2013, showed mild carpal tunnel syndrome (CTS) on the left for which a carpal tunnel splint was recommended. X-rays of the thoracic spine done on December 5, 2013, identified mild anterior wedging of T11 and T12. Per records, it was found that the patient had undergone FCE three times in June, September and December of 2013. It was determined that he was still unable to return to work. A designated doctor examination (DDE) on December 18, 2013, showed that the patient had not reached maximum medical improvement (MMI) and estimated the date of MMI to be January 1, 2014. Finally, the records revealed that the patient was referred for chronic pain management. The patient was kept off work. The patient was kept on PT and was recommended surgery and work hardening program (WHP). The patient's mental history was remarkable for a little depression off and on, but no significant depression. The patient was currently utilizing omeprazole, Sildenafil Citrate, Latan oprost solution, Psyllium SF oral powder and ibuprofen. On examination, he appeared mildly depressed. He noted at times he saw shadows out of the corner of his left eye since ten years. The shadows would come and go on average once a week. Otherwise, mental examination was unremarkable. The patient noted that the anxiety symptoms had started on the same day as the

depressive symptoms. The sleep disturbances got worse after the accident. He was diagnosed sleep apnea before the accident. On the Beck Depression Inventory (BDI), he scored 17 indicating mild-to-moderate level of depressive symptoms. On Beck Anxiety Inventory (BAI), he scored 14 indicating mild level of anxiety symptoms. On the McGill Pain Questionnaire, he scored 25 indicating normal range of scores. On the Fear Avoidance Bellefa Questionnaire, he scored 14 on the physical sub scale and 20 on the work sub scale. On the Disabilities of the Arm, shoulder and hand, he endorsed a score of 43%, indicating a severe disability range of scores. On the Neck Pain Disability Index Questionnaire, he endorsed a score of 40%, indicating a moderate to severe range of scores. He reported problems with pain intensity during work, driving, sleeping and recreation. Ms. diagnosed Axis I: Adjustment disorder with depressed mood and occasional problem and recommended individual psychotherapy six sessions over eight weeks.

Per a pre-authorization request letter dated February 24, 2014, a request for individual/psychotherapy of six sessions over eight weeks was done.

Per the utilization review dated March 3, 2014, denied the request for individual psychotherapy six sessions over eight weeks based on the following rationale: *"The patient is a male whose date of injury is xx/xx/xx. The patient was driving and was rear-ended by a truck. Initial diagnostic screening dated February 10, 2014 indicates that treatment to date includes x-rays, EMG/NCV, MRI, 10 sessions of work conditioning, PT and medication management. Medications are listed as omeprazole, Sildenafil citrate and ibuprofen. BDI is 17 and BAI is 14. McGill Pain Questionnaires score is 25 FABQ-PA is 14 and FABQ-W is 20. Diagnosis is adjustment disorder with depressed mood. Based on the clinical information provided, the request for individual psychotherapy x six is not recommended as medically necessary. There is a lack of documented progress in previous treatment including work hardening program. There is no indication that the patient has been placed on psychotropic medications."*

Per a response to denial letter dated March 7, 2014, appealed for the decision of denial that was made on March 3, 2014, for six sessions of individual therapy over eight weeks. In clarification, it was noted that the request was reasonable to determine if the patient would need further neurological recommendations specifically for his cognitive functioning and/or any other recommendations made by his treating physician. Also, it was noted that the patient had a job position to return to with his employer, however he had concerns regarding his rehab progress. The ODG Psychotherapy Guidelines included initial trial of six visits over three to six weeks totaling up to 13-20 visits over 7-20 weeks of individual sessions.

Per reconsideration review dated March 21, 2014, the appeal for individual psychotherapy six sessions over eight weeks was denied with the following rationale: *"Based on clinical information, peer to peer discussion, TDI-DWC/Medicare Policy LMRP-V158 requiring appropriate intervention for condition, ODG Psychotherapy Guidelines: Initial trial of six visits over six weeks.*

With evidence of objective functional improvement, up to 13-20 visits over 13-20 weeks. ODG Pain Chapter, Behavioral Interventions. ODG Mental Disorder Chapter, Cognitive Therapy for Depression: Recommended ACOEM Chapter 5, Page 91: A number of techniques are available to teach coping skills, depending on the patient's specific needs and skill deficits. Referral to a behavioral health professional trained in these areas may make a very important investment in the patient's overall outcome. ODG Mental Chapter Disorders, Cognitive Therapy for Depression: Recommended ODG Psychotherapy Guidelines. ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain: screen for patients with risk factor for delayed recovery, including fear avoidance beliefs. See fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these at risk patients should be physical therapy for exercise instructions, using a cognitive motivational approach to PT. Consider separate psychotherapy CBT referral after four weeks if lack of progress from PT alone: Initial trial of three to four psychotherapy visits over two weeks. With evidence of objective functional improvement total of up to six to ten visits over five to six weeks (individual sessions). With severe psych co-morbidities (e.g., severe cases of depression and PTSD) follow guidelines in ODG Mental/Stress Chapter, repeated below."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
This patient has been diagnosed, with regard to Mental Health issues, with an Adjustment Disorder with depressed mood. However, in reviewing his scores from his behavioral health evaluation, it is his reaction to pain that is striking. He was noted to have scores that indicate anywhere from a moderate to a severe level of pain and he also indicated significant fear avoidance. Therefore, this patient should be evaluated under ODG guidelines for chronic pain.

"*ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain: screen for patients with risk factor for delayed recovery, including fear avoidance beliefs. See fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these at risk patients should be physical therapy for exercise instructions, using a cognitive motivational approach to PT. Consider separate psychotherapy CBT referral after four weeks if lack of progress from PT alone: Initial trial of three to four psychotherapy visits over two weeks. With evidence of objective functional improvement total of up to six to ten visits over five to six weeks (individual sessions)."*

The record does indicate that this patient has already participated in a PT program, but still complains of pain. Therefore, according to the above quoted guidelines, he should now be eligible for separate psychotherapy CBT referral for lack of progress with PT alone. Therefore the request for 6 sessions of CBT, which is being appealed, should now be approved.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES